



ENROLLMENT FORM FOR STUDENTS AND DISABLED DEPENDENTS

State Form 50674 (R2 / 9-03)

Dear Employee:

Dependents on the State Of Indiana Health, Dental, Life and Vision Plans are eligible for coverage until the end of the calendar year of their 19th birthday. Dependents may be eligible for coverage beyond that time if they are a full-time student or disabled dependent.

Coverage may extend beyond the limiting age if any of the following apply:

1. Dependent is a full-time student at an educational institution. Full-time students may be covered until the end of the calendar year of their 23rd birthday; or
2. Dependent is mentally or physically handicapped.

You must complete this form to continue coverage for each of your dependents if any of the above conditions apply. Return this form to the person in your agency responsible for benefits administration. Do not send this form directly to the carrier(s). Please print clearly.

Name of Employee _____ SSN _____

Name of Agency _____

Student Information

Name of Dependent _____ Date of Birth _____

Dates enrolled full-time: Beginning _____ Ending _____

Name of college, university, or other educational institution: _____

I affirm under penalties of perjury that the forgoing representations are true.

Signature of Employee

Date (month, day, year)

Disabled Dependent Information

Name of Dependent _____ Date of Birth _____

*Nature of disability _____

Signature of Physician (required)

Date (month, day, year)

Printed name of Physician

Phone number

Signature of Employee

Date (month, day, year)

* Carrier may require additional information to verify mental or physical disability.